

STAGES OF CRISIS COUNSELING

- (1) Assessment of Suicidal Potential: Have they had previous thoughts about killing themselves? Have they ever attempted to kill themselves? How would they kill themselves if they were ever to try? How often do they think about killing themselves? Have they ever talked to anyone before about killing themselves? Is the person in a life-situation where they might be prone to feel helpless and hopeless?
- (2) Establish emotional contact with the client: This is concerned with the formation of a relationship with the client. This process begins by the counselor verbally recognizing and accepting the emotional states of the client. Such emotional recognition and acceptance (empathy) establishes emotional contact and communicates to the client that the counselor is a caring and concerned person. With the establishment of emotional contact and the beginning of a relationship, the client can feel more at ease and begin to deal with his presenting complaint.
- (3) Clarification of stresses, emotions and present situation: The stage of clarification is the primary counseling stage for the restoration of proper functioning to the cognitive level. An effort is made in this stage to help a client obtain a more realistic perception of his primary stresses, his interpersonal relationships, his emotional states, and his current crisis situation as it relates to these stresses, emotions and relationships. The more realistically a client perceives his crisis situation, the better able he is to make appropriate crisis reducing decisions and engage in coping behaviors.
- (4) Mobilization of the client's immediate resources: The term "immediate resources" refers primarily to the client's closest significant others (family, friends, minister, etc) but can include more distant relationships (employer, fellow workers, physician, helping agencies, etc.). When in a crisis a person often does not make adequate use of people around him because: (1) he does not see them as helpful; (2) he does not want to bother them; or (3) he has alienated them by his pre-crisis behavior. The stage of mobilization focuses upon making a client aware of these resources and helping him to make the best use of them.
- (5) Develop short-term goals: Goal setting is the stage of enabling a person to decide what needs to be done, i.e., what coping responses are needed. Goals may need to be suggested by the counselor in a more directive manner than usual. Goals need to be immediately achievable, or very short-term and focused on resolution. Goals must also be behaviorally oriented so that the client knows exactly what he must do for crisis resolution.

- (6) Termination and referral: A person in crisis is very suggestible and places himself in a dependent position when he seeks help. It is important to remove a client from this state of dependency so that he can again experience himself as being an independent individual. This goal is accomplished by allowing the client to direct the flow of contact, leaving decisions for action to him, and having a definite termination, i.e., an agreed upon end of contact. If termination does not occur, a client is left feeling dependent and perhaps unsure of his abilities to cope with future problems.

Crisis Management Techniques

1. *Listen actively and with concern.*
2. *Encourage the open expression of feelings.*
3. *Help the person gain an understanding of the crisis.*
4. *Help the individual gradually accept reality.*
5. *Help the person explore new ways of coping with problems.*
6. *Link the person to a social network.*
7. *Engage the person in decision counseling.*
8. *Reinforce newly learned coping devices.*
9. *Follow the person after resolution of the crisis.*

*CALLS WITH SUICIDAL INTENTION

When a person is in a state of crisis has reached the extreme limits of his coping responses and is feeling the depths of frustration and depression, his thoughts may turn to suicide. A person in a suicidal state is feeling HELPLESS and HOPELESS. Death seems to him as the only available alternative. However, intervention is possible even in this serious condition. A suicidal state is a crisis state and the characteristics of a crisis state exist, i.e., (1) a person is "open" to accepting help, (2) a small amount of intervention can bring about dramatic results, and (3) a positive resolution may lead to better adjustment to future crises.

There are two primary characteristics of a suicidal person that should be noted: (1) his ambivalence and (2) his communication of suicidal intentions. A person in a suicidal state is ambivalent about life and death, i.e., he both wants to live and wants to die at the same time. He wants to meet his crisis and to avoid it. This ambivalence can be seen when a person ingests barbiturates and then seeks out help or makes a suicide attempt at a time and place where he is most likely to be quickly found. The strength of these two impulses (to live and to die) will vary between individuals and within the same individual. For most people, the will to live is stronger and this is why they call. It is this ambivalence that makes suicide prevention possible.

It is not a counselor's role to tell a caller he should live as it would not be to tell him to die, for to do so, is often fruitless. A counselor needs to explore with a caller, his reasons for wanting to die, along with reasons to live. Hopefully, his ambivalence will allow the caller's will to live to strengthen and lead to a decision to live.

People, who are suicidal, communicate their desire to die to others. These communications occur in a variety of forms, but an alert observer will perceive them. The most obvious communication is a verbal statement to the effect that "I am going to kill myself" or "I no longer want to live." Sometimes verbal communication is less obvious, "I can't go on, I feel so bad." Most people who are suicidal give some verbal indication either direct or indirect of their intentions. However, many signals of suicide are non-verbal. Emotional level is one indicator. Both acute and chronic sadness or depression, when present with other indicators may signal suicide. Behavioral actions are also indicative. For example, the sudden giving away of possessions or the preparation of a will. The purchasing of a firearm or pills. The signs may often be

noticed but unheeded by family members. Counselors must be aware of these messages.

A crisis call that involves suicidal intention can be handled according to our model for crisis calls if one specific step is added. Our usual model is:

- (1) Offering of emotional support.
- (2) Clarification of stresses and situations.
- (3) Mobilization of immediate resources.
- (4) Goal setting.
- (5) Termination and referral.

With a suicide call, we want to add and focus on the step of the Assessment of Suicidal Potential and to emphasize the mobilization of the caller's immediate resources.

Suicidal potential refers to the probability that a person will engage in self-destructive behavior. There now exist, a number of criteria to be used in assessing suicidal potential. No single criteria is absolutely positive. It is the pattern of criteria that should be rated.

CRITERIA FOR ASSESSING SUICIDAL POTENTIAL

(1) AGE AND SEX: Statistics reveal that the suicide rate increases with advancing age and that men are more successful in killing themselves than are women, although women attempt more frequently. The seriousness of a suicidal communication increases with age and also if the caller is male. A communication from an older male is more dangerous than from a young female. An older woman's threat is more dangerous than that of a young male. A caller's age and sex provide a framework in which to use other criteria.

(2) MOOD: If a caller's mood is tired, depressed or "washed out," then suicidal risk is higher than if he sounds in control of himself. Also, exuberance, flight of ideas, screaming and yelling are ominous signs. A strong denial of suicidal intentions is a definite danger signal as is a marked improvement in mood during the contact. Mood should be carefully evaluated.

(3) PRIOR ATTEMPTS: In 75% of actual suicides, there have been previous suicidal attempts. A report of a previous attempt or attempts increases the level of suicidal potentiality.

(4) ACUTE OR CHRONIC SITUATION: If a caller's stress is sudden and acute, then greater immediate danger exists than in a chronic reoccurring situation.

(5) MEANS OF SELF-DESTRUCTION: Shooting, jumping, and hanging are the most deadly means of self-destruction. If a caller is threatening one of these methods, then the threat is serious and danger high. Pill taking, wrist cutting, use of gas are slower, still deadly, but a person considering these means may not be as serious an immediate threat as the first three methods.

(6) DETAILS OF THE METHOD: If a caller has specified the time, place, and other details of his suicidal plan, along with a method, then danger is higher than when details remain vague and indefinite. *Availability of means*

(7) RECENT LOST OR SEPARATION FROM A LOVED ONE: Danger increases if there is a recent death of a loved one and/or divorce or separation. Separation need not have occurred, but could be pending.

(8) MEDICAL SYMPTOMS: Medical symptoms of a serious chronic nature increase potentiality of suicide. This is especially true if the person is older.

(9) RESOURCES: If a caller is under financial stress, has few friends, is all alone and, in general, has few resources, then suicidal potential increases.

(10) COMMUNICATION: If communication with significant others has deteriorated, or is non-existent, risk increases. If there is no one to talk to, the situation is serious.

These ten criteria are the primary ones for use in assessing suicidal potential. Much misconception has existed about suicide. The following fables about suicide are presented to dissell some of these false beliefs.

****FABLE:** People who talk about suicide don't commit suicide.

FACT: Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions.

FABLE: Suicide happens without warning.

FACT: Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions.

FABLE: Suicidal people are fully intent on dying.

FACT: Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling.

FABLE: Once a person is suicidal, he is suicidal forever.

- FACT: Individuals who wish to kill themselves are "suicidal" only for a limited period of time.
- FABLE: Improvement following a suicidal crisis means that the suicidal risk is over.
- FACT: Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put his morbid thoughts and feelings into effect.
- FABLE: Suicide strikes much more often among the rich-- or, conversely, it occurs almost exclusively among the poor.
- FACT: Suicide is neither the rich man's disease nor the poor man's curse. Suicide is very "democratic" and is represented proportionately among all levels of society.
- FABLE: Suicide is inherited or "runs in the family."
- FACT: Suicide does not run in families. It is an individual pattern.
- FABLE: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.
- FACT: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy he is not necessarily mentally ill.

*Excerpted from: Johnson, Daniel H., Helpline Training Manual, 1974.

**From Some Facts about Suicide by E. S. Shneidman and N. L. Farberman, Washington, D.C., PHS Publication No. 852, U. S. Printing Office.

RECOGNIZING AND HELPING OTHERS WHO MAY BE SUICIDAL

Introduction: About 28,000 Americans commit suicide each year; approximately 400,000 attempts are made. Obviously, when a suicidal tendency is suspected, professional help should be sought. However, non-professionals are often the first to recognize suicidal thoughts, and they may, of necessity, be the first ones to provide initial help. We have asked Dr. Herbert Brown, Instructor in Psychiatry at the Cambridge Hospital, Harvard Medical School, to discuss some of the dynamics relating to individuals with suicidal tendencies.

What Circumstances Make Suicidal Intentions a Serious Risk?

Older, white males are the most likely to carry suicidal thought out to the completed act, although inner city blacks and younger people have shown an increasing trend to do so in recent years. Other high risk categories include professionals, the unemployed, divorced and widowed persons, and those who have suffered a major loss. A person prone to serious depression is at higher risk, as are heavy users of drugs and alcohol. The more factors present, the greater the risk. Finally, 60% of completed suicides have been preceded by an earlier attempt; just because someone has tried and survived does not mean that he or she wasn't or isn't still serious.

Here are some common thought patterns that precede suicide:

- Important in our community
- (1) Some people are vulnerable to a feeling that they are in danger of total abandonment, that they will soon be left without any emotional ties or supports. Often, they rely on a single person to stand between them and the threat of emotional desolation. When that person pulls away, leaves, dies, or changes the style of the relationship, the dependent person experiences extreme anger, which he or she cannot express directly. Instead, it is turned against the self and may be expressed physically as suicide.
 - (2) Individuals who have a generally poor self image may develop an unhealthy dependence on external signs of their worth. For these people, a period of failure—in work, in relationships—can lead to an increased sense of self-disgust, which may then culminate in self-destruction.
 - (3) Some people perceive death as a peaceful, even nurturing, state and don't imagine that they will *really* be dead but rather expect to enter some romanticized state. Many suicidal adolescents have such a concept of death. (As a rule, this notion is not religious; religious beliefs generally discourage suicide.) Painful events in real life may lead such people to try suicide as a way of attaining relief. The attempt is often preceded by a period of withdrawal and psychological preparation.
 - (4) People who suffer major depressions can get stuck in a perspective that sees themselves and their lives as hopeless, worthless and a burden on others.

Besides these general guidelines, one of the most important clues to someone's intentions is your own impression when talking to him or her. If you recognize that the conversation is creating a sense of hopelessness and helplessness in *you*, this is an indication that suicide is possible. Remember: even if suicide is unthinkable to *you*, don't discount the possibility of it being a real option for somebody else.

How Can One Assess and Deal with Suicidal Tendencies in Another?

If someone is in an acute state of despair and begins to drop hints about suicide, assume that the issue is not yet settled. No matter how hopelessly the situation is presented, that person is still open to an alternative. If you are willing to discuss the matter, you may help to diminish the sense of isolation and futility—while at the same time directing the person to professional help.

If suicide is not directly mentioned, but the person seems so miserable or troubled that you wonder whether he or she is considering it, you can bring up the subject yourself. You can phrase your question something like this: “Things sound very difficult. Has it gotten to the point that you’re thinking about killing yourself?” It is all right to be first to use the word “suicide” or an equivalent phrase. You can be sure that you aren’t putting ideas into somebody’s head that weren’t there already. Being silent, on the other hand, may be interpreted as your way of agreeing that things really are hopeless.

If a person has attempted suicide in the past, there is a very high risk that he or she will try again, especially in the first two or three years after a serious attempt. The risk is particularly high if the person is not in treatment. When someone is in this situation, special sensitivity on the part of friends and family may help to avert another episode.

Sometimes, the suicidal individual may seem to get better suddenly, announce that his or her state of mind is much improved, drop out of treatment, stop taking medication, and so forth. All of this activity may reflect a sincere *wish* that things were better. But in reality, improvement is rarely so abrupt, and the wish cannot be trusted as an accurate version of the truth. Worse, such actions may indicate that a decision to commit suicide has been made. Although it is difficult to contradict the person who claims to be satisfied, a sudden upswing—or abrupt departure from a treatment program—may indicate that the situation is really rather fragile. Urge a return to treatment because out of treatment the person may be even more highly vulnerable to suicidal impulses.

When and How Should One Get Additional Help?

While trying to support someone who seems depressed, you may find that you begin to feel increasingly worried, burdened, or inclined to avoid the person. There are two natural responses to this: to withdraw or to feel guilty and think you have to try even harder. These feelings are a signal to you that it is time to get professional help. When you feel it’s too hard to carry on singlehandedly and yet you worry about backing out, the situation is getting risky. Now is the time to urge the depressed person to talk with a professional. If he resists, you may need to get some counseling for *yourself*. Guidance from a mental-health professional can help you to handle matters so that you don’t get stuck in the dilemma of struggling to meet a need when you don’t think you can—and yet fearing the consequences if you don’t keep trying.

Most cities have a telephone listing for a suicide prevention service. The mental health or psychiatry department of a hospital or clinic can also be a source of counseling, support, or information. Through friends or the clergy, you may be able to locate a counselor if these sources aren’t available.

Is Suicide Always Preventable?

After a suicide, family and close friends may brood about what they should have done to prevent it. These feelings need to be openly explored, preferably with a professional. The process can be brief, but it is *very* important. Without it, reactions are likely to fester for a long time.

The natural question that arises is: “Could we have done something to prevent this?” In retrospect, it can be easy to say a suicide seemed either unnecessary or so inevitable that you wonder how the person held on for so long. Such after-the-fact judgments may not reflect before-the-fact uncertainties. Some people are very good at concealing their intentions and seem so determined that there is no stopping them. Even experienced professionals can be fooled. Suicide may be preventable in principle, and yet there are situations in which the best efforts fail.

WHEN A LOVE-RELATIONSHIP ENDS:

DISENGAGING

I. DENIAL: It'll never happen to me!

Ending a love-relationship may be the greatest emotional pain a person will ever experience. The pain is so great, in fact, that one may react with denial or disbelief. This only prevents one from facing the important question, "Why did my love-relationship have to end?" There are rarely simple answers, so it will take some time and effort. Until one can accept the ending, there will be difficulty adjusting and rebuilding.

II. From LONELINESS to Aloneness.

It is natural to feel extreme loneliness with a love-relationship ends. But healing can come from pain, if you listen to it. You can learn how to grow through loneliness to the stage of aloneness -- where you are comfortable being by yourself.

III. GUILT vs. REJECTION.

Some end love-relationships while others have it ended for them. The adjustment process differs since those who end the relationship feel more guilt and those who have it ended for them feel more rejection. They also start their adjustment at different times. Those who end the relationship start their adjustment while still in the relationship. Those who have the relationship ended for them start adjusting later. For the mutuals, people who jointly decide to end the relationship, the adjustment process is somewhat easier.

IV. GRIEF: Big boys -- and girls -- do cry.

Grief is an important part of the disengagement process. You need to work through grief's emotions in order to let go of the dead love-relationship. An intellectual grasp of the stages of grief can help you become emotionally aware of grief. Then you can do the grieving that you may have been afraid of before.

V. ANGER: Damn the S.O.B.!

You will feel a powerful rage when your love-relationship ends. Feeling anger is a natural, healthy part of being human. But anger is different than aggression, which is a destructive form of expressing anger. It's not healthy to keep your anger inside, nor to express it aggressively. You can learn to express both your "divorce" anger and your "everyday" anger constructively.

VI. LETTING GO of the emotional corpse.

At this point in the disengaging process, one needs to give thought to stop investing emotionally in the dead love-relationship. Failure to let go may be a sign that you are not facing some painful feelings within yourself. Those who initiate ending a relationship tend to let go more quickly, often because they have let go even before they left.

VII. SELF-CONCEPT: Maybe I'm not so worthless after all!

It is OK to feel good about yourself. You can learn to feel better about yourself, and thus gain strength to help you adjust better to a crisis. As you successfully adjust to a crisis, you will feel even better about yourself!

VIII. FRIENDSHIPS: Where has everybody gone?

The support you receive from life-line friends is very important and can shorten the time it takes you to adjust to the crisis. You can develop friends of both sexes without becoming romantically and sexually involved.

IX. LEFTOVERS: They're not all in the refrigerator!

Earlier experiences are extremely influential in your life. The attitudes and feelings you develop in relationships with parents, family, friends and lovers are bound to carry over into new relationships, others are not. A common leftover problem, even for adults, is an unresolved need to rebel against prior constraints, such as parental rules. Recognize the valuable leftovers, so you can keep and nourish them; work at changing those which get in the way.

X. LOVE thyself as thy neighbor.

Many people need to relearn how to love, in order to love more maturely. Your capacity to love others is closely related to your capacity to love yourself. And learning to love yourself is not selfish and conceited. In fact, it is the most mentally healthy thing you can do.

XI. TRUST: Foundation for healthy relationships.

If you say, "You can't trust people!" you are saying more about yourself than about anyone else. Love-relationships after the break-up often are attempts to heal your love-wound, so many of them will be transitional and short-term. In your new relationships with others, you may be reworking and improving the way you got along with your parents. By building a basic level of trust within yourself, you can experience satisfying emotionally close and intimate relationships.

XII. SEXUALITY: It's beautiful.

When you are first separated, it is normal to be extremely fearful of sex. However, during the adjustment process, you can develop your personal morality to express your unique sexuality. The singles subculture emphasizes authenticity, responsibility and individuality more than rules. So, you can discover what you believe rather than what is expected of you. The great difference in attitudes and values of male and female sexuality appears to be a myth. But, your adjustment could be complicated by the major changes currently taking place in female and male sex roles.

XIII. RESPONSIBILITY: Let's treat each other as adults!

Many relationships that end in divorce were out-of-balance in terms of responsibility. One partner was over-responsible, the other was under-responsible. When couples try to change this system of interaction, it is often the beginning of the end of the relationship. Feelings and attitudes within keep one operating in the under-responsible or over-responsible style; one may have to make some major changes to become adult. Equal responsibility relationships are more flexible and able to adjust to stress and change, and thus are more likely to last.

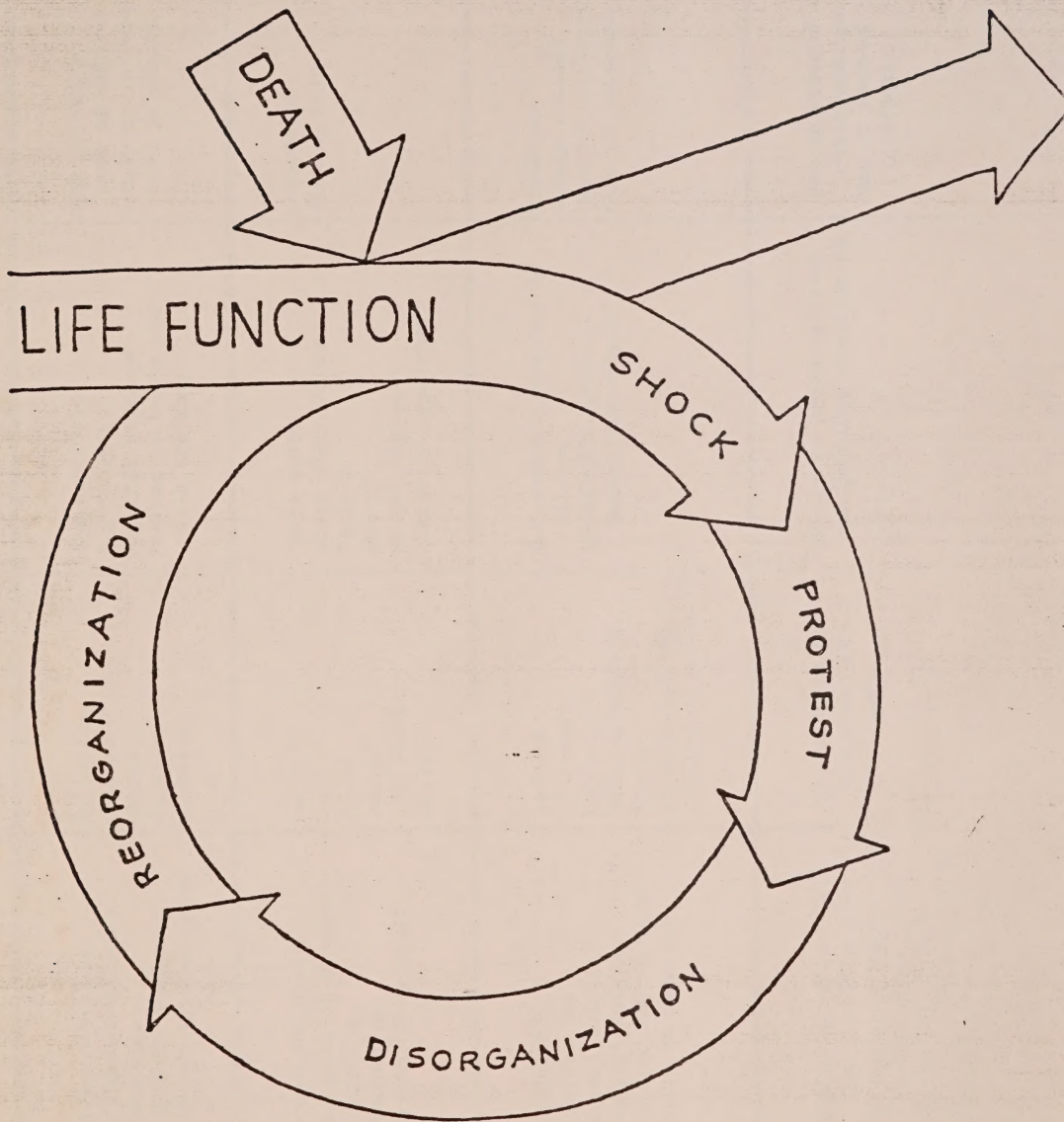
XIV. SINGLENES: You mean it's okay?

In the singleness stage, you emphasize investment in your own personal growth rather than in other relationships. A period of singleness enables you to build confidence in yourself so you can experience and enjoy being single as an acceptable alternative lifestyle, not as a time to be lonely. It is easy, however, to become stuck in this rebuilding block as a means of avoiding another intimate love-relationship.

LIFE FUNCTION



The "Grief Wheel"



POSSIBLE MANIFESTATIONS OF GRIEF

STAGE	THINKING	FEELING	PHYSICAL	SOCIAL	COPING MECHANISM
SHOCK (Hours to a week)	Slowed &/or dis-organized thinking. Blocking. Suicidal thoughts. Wish to join deceased.	Hysteria. Outbursts. Euphoria. Blunting. Numbness.	Hyperactivity. Hypoactivity. Physical numbness. Feeling of being outside the body.	Lack of awareness of others. Passivity in relation to others.	Denial. Intellectualization. Depersonalization.
PROTEST (1st week to 3 months)	Preoccupied with thoughts of deceased. Searching. Rumination. Dreams of deceased.	Sadness Fear Anger Relief Irritability Guilt	Chest pains Sleep disturbance Fatigue Nausea Weight change Change in appetite	Dependence Seeking help	Regression to earlier pattern Projection Introjection
DIS-ORGANIZATION (3 to 6 months)	Confusion Aimlessness Slowed thinking Loss of interest Lowered self-esteem Focus on memories	Sadness Loneliness Depression Meaninglessness Apathy Intense anguish Feeling of unreality	Decreased resistance to illness Deceased's traits & mannerisms adopted	Withdrawn Others avoided Lack of initiative Lack of interest	Regression to earlier level Projection Introjection
RE-ORGANIZATION (6 months to 2 years)	Realistic memory of deceased developed Pleasure in remembering experienced Return to previous level of functioning New meaning in life.	Both sadness and happiness experienced.	Return to previous level of physical functioning	New or renewed social relationships. New or renewed interests.	Former coping mechanisms and/or new ones added.

HOMOSEXUALITY—25 QUESTIONS AND ANSWERS

Purpose of sharing this reprint is to give families (and churches) with homosexual members straightforward answers to some of the most frequently asked questions about homosexuality.

Magazine articles, books, new reporting, movies and public discussion of homosexuality are so plentiful today as to indicate a genuine public concern about the subject and a desire better to understand it. However, the person has difficulty in finding simple, straightforward answers to many of the questions readily available in convenient form.

To help fill this need the following pamphlet has been prepared by a panel of highly qualified social scientists and specialists, each of whom has studied homosexuality extensively and at least one of whom is himself a homosexual. In addition to his study, each of the panelists has done much interviewing and counseling work with male and female homosexuals, gaining thereby a broad insight into the attitudes and behavior patterns of several thousand such persons.

The aim of this publication is to replace misconceptions and fears about homosexuality with a better understanding of the subject. It is hoped that this will result in improved and more humane attitudes toward those men and women for whom homosexuality is their way of life and effect a better integration into society of such individuals, many of whom are worthwhile and useful people. Such a goal would seem to be preferable to the traditional practice of alienating them and increasing the numbers of individuals who are a burden upon society.

heterosexuals would be designated criminals were such laws enforced.

9. ARE CHILDREN SEDUCED INTO HOMOSEXUALITY? Homosexual seduction is no more common than is heterosexual seduction. Numerically it is much less frequent because there are fewer homosexuals. Several surveys have shown that most persons who engaged in homosexuality during their adolescent years did so with those of approximately their own ages. Schofield reports (p. 209) that of one group studied about three-quarters "had started homosexual activity with other boys before the age of seventeen; only a few were initiated by adults."

10. WHAT CAUSES HOMOSEXUALITY? It is not yet known what causes either heterosexuality or homosexuality. It has been held that heterosexuals may be hormonally, genetically and biologically different from homosexuals. Others have argued that a young child's emotional relationships with his or her parents, and those near to the child will determine his or her sexual pattern in adulthood. Much further research will be needed before a definite answer can be given.

11. CAN HOMOSEXUALITY BE CURED? Since homosexuality is merely one of the variations of human behavior and has been considered to be quite normal in some societies during various periods in history a better question might be, "Should homosexuals change? If so, why?" Available statistics indicate that large numbers of homosexuals see no reasons for wanting to change. Many of those who have tried to change have found treatment to be both long-term and expensive, with results often unsatisfactory. Many therapists now favor helping individuals to accept their homosexuality, rather than to seek change.

12. IS HOMOSEXUALITY NECESSARILY A HANDICAP? No one's sexual orientation need be a handicap. Homosexuals and heterosexuals alike can lead happy, productive lives, provided they come to terms with their sexuality. For some persons, however, the social sanctions and public prejudice against homosexuality may create special problems and unhappiness.

13. IS THERE A HOMOSEXUAL PERSONALITY? None has so far been identified. Scientifically administered personality tests have not revealed any clearcut distinctions between heterosexuals and homosexuals, other than that of their sexual preference.

14. WHAT KINDS OF JOBS DO HOMOSEXUALS HOLD? Like other minority groups they have tended to take jobs having the fewest barriers. Thus, they are no more inclined to be hairdressers than blacks are to be janitors. Surveys have shown that homosexuals can be found in every occupational grouping from the ministry to professional athletics and police forces. However, the vast majority of homosexuals must take great pains not to reveal their homosexual inclinations on their jobs, for their efficient and effective job performance is often no protection to them if homosexuality is suspected.

15. ARE HOMOSEXUALS CHILD MOLESTERS? The overwhelming majority of homosexuals have no interest in pre-adolescent children. Their interest in adolescents is no greater or more significant than that of heterosexuals. Pederasts, those adults who do seek sexual contacts with young children present a difficult and often tragic problem but this should be clearly distinguished from homosexuality. According to studies of such offenders in prison, the majority of pederasts are, or have been, married men.

16. ARE HOMOSEXUALS AS PROMISCUOUS AS CLAIMED? Not necessarily. However, because of the nature of social pressures they face, it is more difficult for homosexuals to establish long-term stable relationships than it is for heterosexual couples. Research indicates that there are many long-term homosexual relationships, sometimes referred to as "marriages."

1. WHAT IS HOMOSEXUALITY? It is the condition of being sexually attracted and drawn to members of one's own sex.

2. WHO IS HOMOSEXUAL? The only basis for deciding whether one is or is not homosexual is a continuing erotic preference for partners of the same sex.

3. DOES A HOMOSEXUAL ACT MAKE ONE A HOMOSEXUAL? No. Many boys and girls during early childhood and adolescence have homosexual experiences without lasting effects. Also, under special circumstances, such as military service and prison life, homosexual behavior sometimes occurs on a temporary basis.

4. HOW MANY HOMOSEXUALS ARE THERE? No one really knows. However, several authorities have estimated that perhaps one out of every ten adults could be so classified. Therefore, the number would total many millions.

5. CAN HOMOSEXUALS BE EASILY IDENTIFIED? Contrary to popular belief most homosexual men and women are indistinguishable in appearance from other people. They are found in all walks of life, at all social and economic levels, and among all cultural groups. Homosexual tastes and personalities vary as widely as do heterosexual. Some male homosexuals are feminine in manner and appearance and some female homosexuals seem masculine. Transvestites, those who prefer the clothing of the opposite sex, and transsexuals, those who feel they are trapped in the body of the wrong sex and therefore seek surgery, usually have a psychological makeup quite different from that of most homosexuals.

6. IS HOMOSEXUALITY UNNATURAL? From a scientific point of view it is not. It would seem to be one of the natural variations of human sexuality which some societies are more willing to accept than others. Endocrinologist Harry Benjamin, M.D., has written, "Do we know what 'normal' means? I don't know. I believe that we only know what is customary."

7. ARE HOMOSEXUALS MENTALLY ILL? No. To label homosexuality as a mental illness reflects a value judgment based on social and religious attitudes, rather than on scientific evidence. Some homosexuals, like some heterosexuals, do indeed suffer from anxiety, or other psychological difficulties. Quite often this has been brought on by pressures from a society which is intolerant and uninformed concerning homosexuality.

8. ARE HOMOSEXUALS CRIMINALS? Homosexuals are no more nor less law-abiding than the rest of the population. However, the laws of most states against oral-genital, anal and masturbatory behavior do label homosexual acts as criminal. The majority of

17. **WILL HAVING HETEROSEXUAL RELATIONS SOLVE ANYTHING?** The homosexual who has already identified himself or herself as such is seldom swayed by having some heterosexual experiences, especially if they are sought out of desperation or anxiety. Homosexuals who try marriage as a way out usually end up by making not only themselves miserable but the spouse as well. Children of such marriages are also caught up in the tragedy.
18. **SHOULD HOMOSEXUALS TRY TO RESIST THEIR SEX URGES?** It would be as unrealistic to expect homosexuals to practice complete sexual abstinence as to expect heterosexuals to do the same. Undoubtedly some homosexuals manage, as do some heterosexuals, to remain celibate throughout their lives, but most people would find this not only impossible but undesirable.
19. **WILL CLOSE PERSONAL RELATIONSHIPS BETWEEN ADOLESCENTS AND ADULTS OF THE SAME SEX LEAD TO HOMOSEXUALITY?** This fear of intimate friendships, particularly between males, has had negative effects on the mental well-being and normal relationships of men to each other in the estimation of many researchers. It is perfectly natural for an adult male to express love and affection for another man or for an adolescent without being homosexual. Displays of affection between males are commonplace in many countries of the world and even in the United States it is not considered inappropriate for women to show warm affection for each other. Male fear of establishing intimate relationships seems due to the prevailing tremendous misunderstanding about what homosexuality actually means.
20. **WHAT DANGERS DO HOMOSEXUALS ENCOUNTER?** One of the consequences of being a member of a disdained minority group is that homosexuals are frequently victimized by blackmailers and unscrupulous police. Since known homosexuals are excluded generally from employment by government agencies and from membership in the armed forces, blackmailers may threaten them with exposure. Some homosexuals would rather pay money to such persons than to lose their jobs. Entrapment procedures are often used against homosexuals; that is, in order to make an arrest the police sometimes encourage homosexuals, or even make advances to them. Such abuses would be eliminated if the so-called sex laws were changed.
21. **IF THE SOCIAL AND LEGAL SANCTIONS AGAINST HOMOSEXUALITY WERE REMOVED WOULD IT INCREASE?** Social and legal equality for homosexuals would undoubtedly lead to more openness about homosexuality. This might lead some people to think there had been an increase. It is also likely that some "borderline" cases, those who might have been trying to seek a heterosexual adjustment would be less willing to do so. However, since homosexual tendencies are not usually acquired by choice, the state of the law would be unlikely to make any difference in the number of homosexuals. The vast majority of people would remain heterosexual as at present. In countries having had legal freedom for homosexual behavior for many years this has apparently been the usual result.
22. **DOES HOMOSEXUALITY CAUSE SOCIETIES TO DECLINE?** A careful study of history would tend to indicate that there is no discernible connection between the state of a nation's fortunes and its attitude toward homosexual behavior. The decline of Rome, for example, was due to many social and economic factors including an inability to successfully transfer power from one ruler to another. Homosexuality in itself was not a factor.
23. **WILL PUBLIC DISCUSSION OF HOMOSEXUALITY LEAD TO ITS INCREASE?** One of the best ways to reduce misinformation, misconceptions and myths about sex is to openly discuss such matters with young people at a time when they are most interested in the topic. The notion that the way to protect young people from something is to keep them in ignorance of it betrays not only a strange lack of confidence in the good sense of the younger generation but also goes contrary to what we know about the learning process.
24. **SHOULD PARENTS DISCUSS HOMOSEXUALITY WITH THEIR CHILDREN?** There should be frank discussions of this and other subjects if young people are to be helped in working through their adolescent difficulties over sex orientation. Also, parents,

teachers, athletic coaches, and all others who deal with young people need to clarify their own attitudes concerning homosexuality. Rejection of a young person will not help him or her and may do incalculable harm.

25. **WHERE CAN MORE INFORMATION AND HELP BE OBTAINED?** The Institute for the Study of Human Resources, of Los Angeles (see address on cover) maintains up-to-date lists of agencies and professionals available for counseling and other assistance in various parts of the United States. Inquiries stating the need and situation may be addressed to the Institute and are invited. For those wishing to have a short list of books and publications in order to further inform themselves about homosexuality a brief bibliography is given below.

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BIBLIOGRAPHY

- 1.—Wainwright Churchill, M.D., *Homosexual Behavior Among Males*, 1967
- 2.—John H. Gagnon, Ph.D. & William Simon, Ph.D., Editors, *Sexual Deviance*, 1967
- 3.—Martin Hoffman, M.D., *The Gay World*, 1968
- 4.—Evelyn Hooker, Ph.D. (Chairman) *Report of Task Force on Homosexuality*, 1969. (Reprinted in ONE Institute Quarterly, Volume III)
- 5.—H. Montgomery Hyde, *The Love That Dared Not Speak Its Name*, 1970
- 6.—Judd Marmor, M.D., Editor, *Sexual Inversion*, 1965
- 7.—Michael Schofield, *Sociological Aspects of Homosexuality*, 1955
- 8.—Ralph W. Weltge, Editor, *The Same Sex*, 1969
- 9.—Donald J. West, M.D., *Homosexuality*, 1955
- 10.—Sir John Wolfenden, Chairman, *Report of the Committee on Homosexual Offences and Prostitution*, 1957

THE MENTAL HEALTH ASSOCIATION

COMMUNITY SERVICE GUIDE

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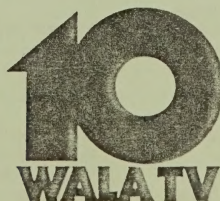
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Emergency, Fire, Police, Ambulance, Rescue	911
Alabama State Troopers	661-4993
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Battered Women	432-1730
County Sheriff	690-8633
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Forest Ranger	1-800-672-6912
Contact Mobile	342-3333
Information & Referral (D.P.S.)	694-2745
Men's Anonymous for Non-Violence	479-8950
Mobile Community Organization	433-9502
Mobile Rescue	432-4433
Police (Mobile)	438-7211
Rape Crisis	473-7273
Red Cross	438-2571
Service Center (Food & Clothing)	432-4096
Traveler's Services	438-1625
U.S. Coast Guard	690-2211

AGED

Adopt-A-Friend	438-2129
Adult Protective Service (DPS)	694-2719
Area Agency on Aging	433-6541
Caregivers Program	433-3206
Cathedral Place Apartments	433-6517
Central Plaza Towers	473-4482
Crowns (Coping Problems)	473-4423
Day Care for Elderly	478-3311
Franklin Clinic	432-4117
Gulf Coast Home Health Agency	473-8681
Hire Older Workers	460-4358
Home Health Nursing	690-8130
Home Nursing Services, Inc.	479-8920
Information & Referral	694-2745
Legal Advocacy for Elderly	479-0649
Mid-South Home Health	471-3856
Operation "Good Morning"	479-0631
Quality Care	476-8212
Retired Senior Volunteer Program	478-7787
S.A.I.L. (Meals)	433-6541
Senior Citizen Services (Mobile)	478-3311
Senior Citizen Services (Prichard)	457-3381
Senior Companion Program	471-3313
Social Security	690-2222
Visiting Nurses Association	438-4731
Y.M.C.A.	438-2130

ALCOHOL & DRUG PROBLEMS

Al-Anon Family Groups	470-9166
Alcoholics Anonymous	432-5896
Brookwood Lodge	633-0900
Center For Life Decisions	432-5414
Charter Southland	432-8811
Crossroads	476-2800
Dauphin Way Lodge	438-4729
Doctor's Hospital, Unit I	433-4666
Gateway Drug Treatment (MHC)	473-4423
Home of Grace For Women	456-7807
M.A.D.D.	675-3403
Mission of Hope Farm (Men)	649-0830
NCASWA Council on Alcoholism, Inc.	433-5456
New Leaf	661-6635
Parade Against Drugs	473-3673

CHILD ABUSE

Boy's Clubs	432-1235
DPS - Abuse & Neglect	432-8570
Juvenile Division - MPD	438-7301
Parents Anonymous	342-3333

CHILDREN & YOUTH

Adolescent Program	432-8811
Albert Brewer Center	633-0400
Board of School Commissioners	690-8083
Boy Scouts	476-4600
Boy's Clubs	432-1235
Catholic Children/Family Services	438-1603
Child Day Care (DPS)	432-8570
Child Day Care Association	
Annie L. Harrison Center	433-1310
Roger Williams Center	473-4063
Child Welfare Information	432-8570
Child, Youth, & Family Services (MHC)	432-0233
Children's Dental Clinic	690-8140
Children's Learning Disabilities Program	479-4969
Christian Home Service Board	452-4243
Community Activities	438-7129
Cornerstone	666-6005
Counseling (MHC)	473-4423
Crippled Children's Services	479-8611
Dumas Wesley Child Day Care Center	479-0649
Family Counseling Center	471-3466
Florence Crittenton Home	479-8585
Franklin Clinic	432-4117
Girl Scouts	344-3330
Head Start (Mobile Community Action)	457-5700
Infant Stimulation	479-1234
Job Corps	342-8640
Learning Disabilities (Rotary Clinic)	431-3428
Libra House	433-7677
Libra House Group Home	433-9053
Maternity & Infant Care (Bd. of Health)	690-8120
Mental Health Association	438-2129
Mental Health Center	473-4423
Mobile County Youth Crisis Center	690-8453
Mobile County Health Department	690-8158
Recreation Department	438-7472
Red Cross	438-2571
Rotary Clinic/Learning Disabilities	431-3430
St. Mary's Home	344-7733
School Counseling & Health Service	690-8200
Sojourn	433-4333
Spring Hill School/Special Children	342-3122
Teen Line (Crisis Line)	433-8336
The Learning Tree	649-4420
Wilmer Hall	342-4931
USA Child Psychiatric Clinic	471-7476
Y.M.C.A.	438-2130
Youth Center	476-1450
Y.W.C.A. (Dericotte)	478-8489

CLOTHING

Goodwill Industries	471-1581
Jr. League Thrift Shop	471-2189
St. Vincent de Paul	432-5173
Salvation Army (Mobile)	438-1625
Salvation Army (Prichard)	452-2036
Service Center	432-4096
Wilmer Hall Thrift Shop	471-3017

DISASTER

American Red Cross	438-2571
Civil Defense	460-8000
Salvation Army	438-1625

DRUG THERAPY

Brookwood Lodge	633-0900
Center For Life Decisions	432-5414
Charter Southland	432-8811
Crossroads	476-2800
Doctor's Hospital, Unit I	433-4666
Gateway Drug Treatment (MHC)	473-4423
New Leaf	661-6635

EMPLOYMENT

Boy's Club (Youth)	432-1235
J.T.P.A. (formerly C.E.T.A.)	476-3090
Hire Older Workers	342-8640
Job Service	342-8640
Mobile Urban League	432-1748
Vocational Rehabilitation Services	479-8611

FAMILY & MARRIAGE

Agape	666-5002
Catholic Social Services	438-1603
Dumas Wesley Community Center	479-0649
Family Counseling Center	471-3466
Family Planning (Board of Health)	690-8113
Follow Up & After Care (MHC)	473-4423
Formerly Married	432-2346
Parents Without Partners	457-0517
Penelope House	432-1730
School Board Counseling Service	690-8200

FINANCIAL

Aid To Dependent Children	690-6216
Better Business Bureau	433-5494
Child Support (DPS)	690-6233
Dept. of Pensions & Securities	694-2745
Social Security	690-2222
Unemployment Claims	342-0820
Veterans Affairs	690-8578

FOOD

Agency's Food Bank	432-3208
Food Stamps	432-1163
Loaves & Fish	433-1842
S.A.I.L. (Meals)	433-6541
Salvation Army	438-1625
Service Center	432-4096
W.I.C.	690-8829

HEALTH PROBLEMS

American Diabetes Association	1-800-824-7891
American Red Cross	438-2571
Arthritis Foundation	471-1725
Cancer Society	476-5406
Cerebral Palsy	479-1234
Cystic Fibrosis	476-5959
Easter Seal Rehabilitation Center	478-8582
Epilepsy	432-0970
Genetic/Birth Defects Center	476-6325
Heart Association	343-5982
Home Health (Nursing) Services	438-2129
Kidney Foundation	433-9040
Lung Association	433-1849
March of Dimes (Birth Defects)	479-9267
Medical Society	433-1804
Medicare	690-2222
Mobile County Health Department	690-8158
Multiple Sclerosis	473-1684
Muscular Dystrophy	1-504-454-6024
Regional School for Deaf & Blind	633-0241
School Health Services	690-8200
Sickle Cell Anemia	476-7778
Tel-Med	471-7030
V.A. Outpatient Clinic	690-2875
V.D. Clinic	690-8153
Visiting Nurse Association	438-4731

HOSPITALS & CLINICS

Charter Southland	432-8811
Doctor's Hospital	438-4551
Franklin Clinic	432-4117
Genetic/Birth Defects	476-6325
Knoivwood Park Hospital	661-5020
Mobile Infirmary	431-2400

HOSPITALS & CLINICS (continued)

Providence Hospital	438-7611
Rotary Clinic	431-3417
Searcy State Hospital	432-1480
Springhill Memorial Hospital	344-9630
Suburban Hospital (Satsuma)	675-1541
U.S.A. Medical Center	471-7000
V.A. Outpatient Clinic	690-2875
V.D. Clinic	690-8153
Villa Mercy Hospice	626-2694

HOUSING

Cathedral Place Apartments	433-6517
Central Plaza Towers	473-4482
Mobile Housing Board	438-7536
Prichard Housing Authority	456-3324
Salvation Army	438-1625

LEGAL

Attorney Referral	433-9790
Bankruptcy Court (U.S.)	690-2391
Legal Advocacy for Elderly	479-0645
Legal Services	433-6560
Mobile Legislative Delegation	660-1023
Probate Court	690-8502
State Parole/Probation Office	690-6482

MENTAL HEALTH

Bayview Professional Associates	661-6633
Charter Southland Hospital	432-8811
Child Guidance Center	690-8330
Doctor's Hospital, Unit I	433-4666
Follow Up & After Care (MHC)	473-4423
Mental Health Association	438-2129
Mental Health Center	473-4423
Mental Health Center - Saraland	675-8701
Mostellar Clinic (MHC) Bayou La Batre	433-8531
Penelope House-Counseling Services	479-8950
Personal Adjustment Center	471-1502
Recovery, Inc.	438-2129
Spring Hill School for Special Children	342-3122
U.S.A. Teaching Clinic	471-7476
Vocational Rehabilitation Services	479-8611

MENTAL RETARDATION

Albert Brewer Center	633-0400
Association for Retarded Citizens	479-7409
Baptist Children's Home	342-5681
L'Arche Mobile (Hope)	438-2094
Public School/Special Education	690-8347

PHYSICALLY HANDICAPPED

Caregivers Program	433-3206
Cerebral Palsy	479-1234
Crippled Children Services	479-8611
Easter Seal Rehabilitation Center	478-8582
Goodwill Industries	471-1581
Mobile Association for the Blind	473-3585
Mulherin Custodial Home	471-1998
Nursing Homes	438-2129
Pre-School for the Deaf	471-6262
Rotary Clinic	431-2339
Services for the Blind - Library	479-7472
The Learning Tree	649-4420

PRE-NATAL

Agape	666-5002
Childbirth Education Association	344-9984
Choice	344-8224
Emergency Pregnancy Service	471-6101
Florence Crittenton Home	479-8585
Health Horizons	342-1000
LaLeche League	473-9849
Maternity & Infant Care	690-8120

PRE-NATAL (continued)

Red Cross	438-2571
Sav-A-Life	342-3131
W.I.C. (Pre-Natal/Pregnancy/Women)	690-8829

RAPE

Emergency	911
Police	438-7211
Rape Crisis Center	473-7273
Sheriff	690-8633

RECREATION

Boy Scouts	476-4600
Boy's Club	432-1235
Boy's Club (Crichton)	478-7811
Catholic Youth Organization	438-1507
City Recreation	438-7472
Community Activities Program	438-7128
Girl Scouts	344-3330
Mentally Restored (Phoenix Club)	438-2129
Mobile Public Library	438-7073
Senior Citizens Services	478-3311
Y.M.C.A. (Chandler Branch)	344-4856
Y.M.C.A. (Dearborn)	432-3037
Y.M.C.A. (Downtown)	438-1163
Y.W.C.A. (Juliette Dericotte)	478-8489
Community Activities Program	438-7128

REHABILITATION

Easter Seal Rehabilitation Center	478-8582
Goodwill Industries	471-1581
Mobile Association for the Blind	473-3585
Rotary Center - Spinal Injuries	431-2339
Vocational Rehabilitation Services	479-8611
Y.M.C.A. (Downtown)	438-1163

SELF HELP

Adult Education	690-8341
Al Anon Family Groups	470-9166
Alcoholics Anonymous	432-5896
Alzheimers Disease	(ext. 520) 438-4551
Association for Downs Syndrome	661-1384
Church for the Deaf	452-9596
Compassionate Friends	471-1511

SELF HELP (continued)

Emotions Anonymous	342-5035
Emphysema Anonymous	457-6619
Family Support Group (Schizophrenics)	438-2129
Follow Up & After Care (MHC)	473-4423
Gam Anon - Families	478-6868
Gamblers Anonymous	473-6067
J.T.P.A.	476-3090
Job Corp (Youth)	342-8640
Men's Anonymous For Non-Violence	479-8950
Mobile Community Action	457-5700
Mobile Urban League	432-1748
Narcotics Anonymous	438-2129
Parents Anonymous	342-3333
Recovery, Inc.	438-2129
Recreation Dept. - Community Activities	438-7128
Survivors of Suicide	438-2129
Terrap Program (Agoraphobia)	344-1482
U.S. Singletons	666-4549

SEXUAL CONCERNS

Catholic Social Services	438-1603
Family Counseling Center	471-3466
Mental Health Center	473-4423
Potency Restored	(ext. 645) 438-4551
Rape Crisis	473-7273
Tel-Med	471-7030

TRANSIENT HOUSING

Mobile Rescue Mission (Men)	433-1847
Salvation Army (Men)	438-1625
Salvation Army (Women/Children)	438-1075
Traveler's Services	438-1625

VETERANS

Red Cross	438-2571
V.A. Outpatient Clinic	690-2875
Veterans Affairs	690-8578
Veterans Center	694-4194

VOLUNTEERS

Caregivers Program	433-3206
Red Cross	438-2571
R.S.V.P.	478-7787
Volunteer Mobile	479-0631

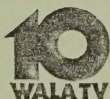
BALDWIN COUNTY

Bay Minette Infirmary	937-5521
Board of Health: Bay Minette	(Ext. 217) 928-0860
Dept. of Pensions & Security: Bay Minette	937-2551
Legal Services: Bay Minette	928-0067
Mental Health Center: Bay Minette	937-2010
Villa Mercy Hospice: Daphne	626-2694
Y.M.C.A. (Eastern Shore Outreach) Daphne	626-9179
Board of Health: Fairhope	928-5504
Family Planning: Fairhope	928-1103
Mental Health Center: Fairhope	928-2871
Social Security: Fairhope	928-2310
South Baldwin Hospital (Foley)	943-5051
Thomas Hospital: Fairhope	928-2375
Health Office: Foley	943-2342
Mental Health Center: Foley	943-6646
Transitional Home: Foley	943-1430
Food Stamp Office: Robertsedale	947-7325
Mental Health Center: Robertsedale	947-7331
Mental Retardation: Robertsedale	947-7304

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YOUR MENTAL HEALTH ASSOCIATION

In Cooperation With



A UNITED WAY AGENCY

AGENDA

10:00 - 10:30 CHECK-IN

10:30 - 12:30 CRISES

12:30 - 1:00 LUNCH

1:00 - 1:30 CONFLICT

1:30 - 3:00 SUICIDE

3:00 - 3:15 BREAK

3:15 - 4:45 SEXUALITY

4:45 - 5:15 CHECK OUT

PLEASE RESPECT EACH OTHER'S
CONFIDENTIALITY. ANYTHING SHARED
IN THIS ROOM STAYS IN THIS ROOM.

AIDS

ACQUIRED IMMUNE DEFICIENCY SYNDROME

1. What is it?

2. Who is
affected?

3. Can it be
prevented?

4. What are the
symptoms?

5. Where can I
go for help?

In the summer of 1981, the medical community in Boston became aware of reports from New York and California of two rare and potentially serious illnesses that were affecting otherwise healthy, young homosexual men. Since that time, these illnesses have also affected exclusively heterosexual men, women and people outside of the United States. Individuals with these illnesses have been diagnosed and treated in Boston since the recognition of the problem.

Information concerning this condition, now called **AIDS**, has been widespread throughout the popular press. Unfortunately, many misconceptions and some incorrect information have arisen concerning the physical, emotional and spiritual issues that relate to these new diseases. As concerned health care providers, in conjunction with the Office of the Mayor of Boston, we have prepared this brochure to help make available the most accurate, clear and up-to-date information on AIDS. We hope that it will help the gay, bisexual and straight communities deal more effectively with this syndrome.

WHAT IS AIDS AND WHO IS AFFECTED?

AIDS is a shortened version of Acquired Immune Deficiency Syndrome, a group of illnesses and symptoms which, taken together, form a similar medical picture. **The immune system** is made up of parts of the body which function to fight infection and which may also help the body rid itself of abnormal cells that might produce cancer. With AIDS, the normal functioning of the immune system is severely impaired and individuals may become vulnerable to infections and other illnesses which rarely affect the average person. Two of the diseases that are often involved are: Kaposi's sarcoma (KS), which is an unusual form of cancer, and *Pneumocystis carinii* pneumonia (PCP), an uncommon infection of the lungs.

Seventy-five percent (75%) of those individuals who are affected by AIDS have been homosexual and bisexual men. It is important to realize, however, that some women, some individuals outside of the United States and some heterosexual men have also developed AIDS. Thus, AIDS should not be considered a "gay plague" or a "gay cancer" but rather a **public health issue**. It has so far affected at least two people per day since 1981 for a total of more cases than Legionnaire's disease, Toxic Shock and the Tylenol product tamperings combined. Approximately 40% of those persons affected by AIDS have died. All of

us — gay, bisexual and straight — should be aware of and concerned about this growing problem.

As yet, it is unknown exactly why one person develops AIDS, while another person does not. Some scientists think that there may be an infectious process which causes AIDS, while other scientists are less certain. During this period of scientific uncertainty, it seems prudent that all of us consider those lifestyle factors that help or hinder us from maintaining a normally-functioning immune system. It is hoped that this type of personal and community-wide activity will diminish the likelihood that others will become affected by AIDS.

PREVENTING AIDS

No one risk factor has been definitively implicated in producing AIDS. It seems, however, that the number of different sexual partners that one has may be an important factor. If there is an infectious process that causes AIDS, then having many different partners probably increases the risk of exposure. It also seems wise that all of us observe some positive health practices that will optimize the operation of our immune defenses. These include: abstaining from intravenous drug use and heavy "recreational" drug use in general, maintaining healthy nutritional and hygienic practices, and seeking regular medical care from an **informed** practitioner.

So far, no one has been able to further define other risk factors that are specific for AIDS. However, if you have more than one sexual partner, we advise that you get regular medical check-ups which screen for sexually transmitted disease. These illnesses, if they occur frequently, may be a contributing factor. Other factors being studied include: the use of nitrite drugs ("poppers"), anal sex, "rimming" (oral-anal sex), swallowing semen and poor nutrition. We do not know, as yet, their role, if any, in producing the AIDS picture. Once again, be aware that the frequency of sexual activity does not appear to be a factor in acquiring AIDS, but instead it is the **number of different** sexual partners that may be relevant.

WHAT ARE THE SIGNS OF AIDS?

AIDS is a complex and serious illness that develops gradually over time. Any one of the signs listed below (or more than one) is a cause for concern, but it is not a reason to panic. The important point is to **take stock of your own health**. Seek medical attention if

you suspect that one or more of the following symptoms may be occurring in you:

- Multiple or enlarging lymph nodes (swollen glands) in the groin, neck or armpit (although there are many other conditions which can cause this problem, most of which are not serious)
- Weight loss of 10 pounds or more in two months that does not appear to be related to dieting or increased physical exercise
- Fever or night sweats, with or without shaking chills, that appear unrelated to a cold or viral infection and which do not appear to be improving
- Persistent diarrhea
- Purplish bumps or spots on the skin, inside of the mouth, nose or anus that do not heal promptly
- Severe fatigue (extending over more than one week) which persists despite having your usual periods of rest and in the face of maintaining your normal diet
- Shortness of breath unassociated with exertion, especially in association with a dry cough unrelated to smoking

Be aware that there is no **one** symptom or sign of AIDS and no **single** screening test that can tell you if you have AIDS. However, many different illnesses can occur in the person with AIDS and these can be diagnosed and treated. We should all be alert to the signs described above in ourselves, our friends and our sexual contacts. As is true in most illnesses, **prompt recognition and treatment** is helpful. Therefore, be alert to the potential signs of AIDS and seek medical help if you suspect they may be occurring.

WHAT TO DO IF YOU HAVE A QUESTION ABOUT AIDS

If you have one or more of the potential warning signs of AIDS, or if you have a general question concerning AIDS, there are a number of resources that can provide help. For general questions call:

Community Epidemiology Department	
Boston City Hospital	(617) 424-5916
Fenway Community Health Center	(617) 267-7573
Lesbian and Gay Hotline	(617) 426-9371
National Gay Task Force Hotline	1-800-221-7044

Sometimes it is difficult for gay men, who appear to be at an increased risk of acquiring AIDS, to get the best health care. In some instances, we are reluc-

tant to notify our medical providers of our sexual preferences because we are uncertain about their attitudes. In other cases, it is our providers who are not well versed in the diagnosis and treatment of illnesses related to gay sexuality. For whatever reason, it is essential to discuss AIDS and to be evaluated for it by someone who is **knowledgeable** about the issue and aware of your sexual preference and your sexual activity. If you cannot do this with your current medical care giver, call one of the above numbers for a referral to a physician or clinic where you can be open about your sexual preference.

COPING WITH AIDS

The recognition of AIDS as a national health issue is causing controversy in the gay community and at the same time stirring many of us to do some important self-searching. Sometimes, in the course of these reflections, the AIDS issue can lead us to inappropriate thoughts and feelings of fear, panic and guilt. If you have any of these thoughts and feelings, it is important to realize that **you do not have to cope with them alone**. The Gay and Lesbian Counseling Services of Boston (617-542-5188) and the Fenway Community Health Center (617-267-7573) are prepared to offer appropriate guidance and referrals.

Moreover, we should all be aware that a national effort is underway to find the cause and treatment of AIDS. In New England, there are many resources for gay, bisexual and straight people who are concerned about these issues. One such resource is the AIDS Action Committee (617-267-7573), a grass roots group, organized through the Fenway Community Health Center, which is dedicated to education, outreach, advocacy and consciousness-raising. They provide discussion groups and support. No one should feel alone with his or her feelings or medical problem. If you are concerned, seek help today.

HOW YOU CAN HELP

If you wish to join forces with those persons working on the AIDS issue, one very easy and critical act is to send a copy of this brochure to your Congressional Representative and Senators. In your cover letter, ask their support for federal funding for research into the cause and treatment of AIDS. More specifically, seek the continued and increased funding of the Centers for Disease Control and the National Institutes of Health.

To find out the name of your Representative, call the Massachusetts Gay Political Caucus at

(617) 262-1565 or the League of Women Voters at
(617) 357-5880. Address your letters to:

Senator _____
Senate Office Building
Washington, D.C. 20510

Representative _____
House Office Building
Washington, D.C. 20515

ABOUT THIS BROCHURE

This material has been prepared by the Mayor's Ad Hoc Committee on AIDS, the Fenway Community Health Center and the Gay and Lesbian Physicians of New England (GALPONE). The project has been funded by the Trustees, Boston Health and Hospitals.

The **Mayor's Ad Hoc Committee on AIDS**, formed by the Mayor's Liaison to the Gay and Lesbian Community in response to the AIDS issue, is made up of representatives of the Centers for Disease Control, the State Department of Health, the Boston Department of Health and Hospitals, the Fenway Community Health Center and representatives of the gay and lesbian community.

The **Fenway Community Health Center** provides a comprehensive primary care program which integrates its commitment to the greater Boston gay and lesbian community along with its basic commitment to the local elderly and young adult population. The clinic is also involved in extensive infectious disease research.

The **Gay and Lesbian Physicians of New England (GALPONE)** is an association for support, educational outreach and recreation.

For further information on these sponsors or for additional copies of this brochure, please contact:

The Mayor's Ad Hoc Committee on AIDS
Room 608, Boston City Hall
Boston, MA 02201/(617) 725-4849

The Fenway Community Health Center
16 Haviland Street, Boston, MA 02115
(617) 267-7573

GALPONE
P.O. Box 971, Back Bay Annex
Boston, MA 02117/(617) 482-6874

SPECIAL THANKS

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MAD - Glad - SAD - Scared

- Step #1 - Listen to their story
- Step #2 - Account for their feelings - give credibility
- Step #3 - Identify the stressors they are under
- Step #4 - Quickly assess their medical potential
- Step #5 - Understand their defense mechanisms.
- Step #6 - Available support systems - Help determine them
- Step #7 - Formulate ~~an~~ a short term plan.
- Step #8 - Follow-up
- Step #9 - Referral - if appropriate

Gay Help Line

AGENDA

10:00-10:30 CHECK-IN

10:30-12:30 CRISES

12:30-1:00 LUNCH

1:00-1:30 CONFLICT

1:30-3:00 SUICIDE

3:00-3:15 BREAK

3:15-4:45 SEXUALITY

4:45-5:15 CHECK OUT

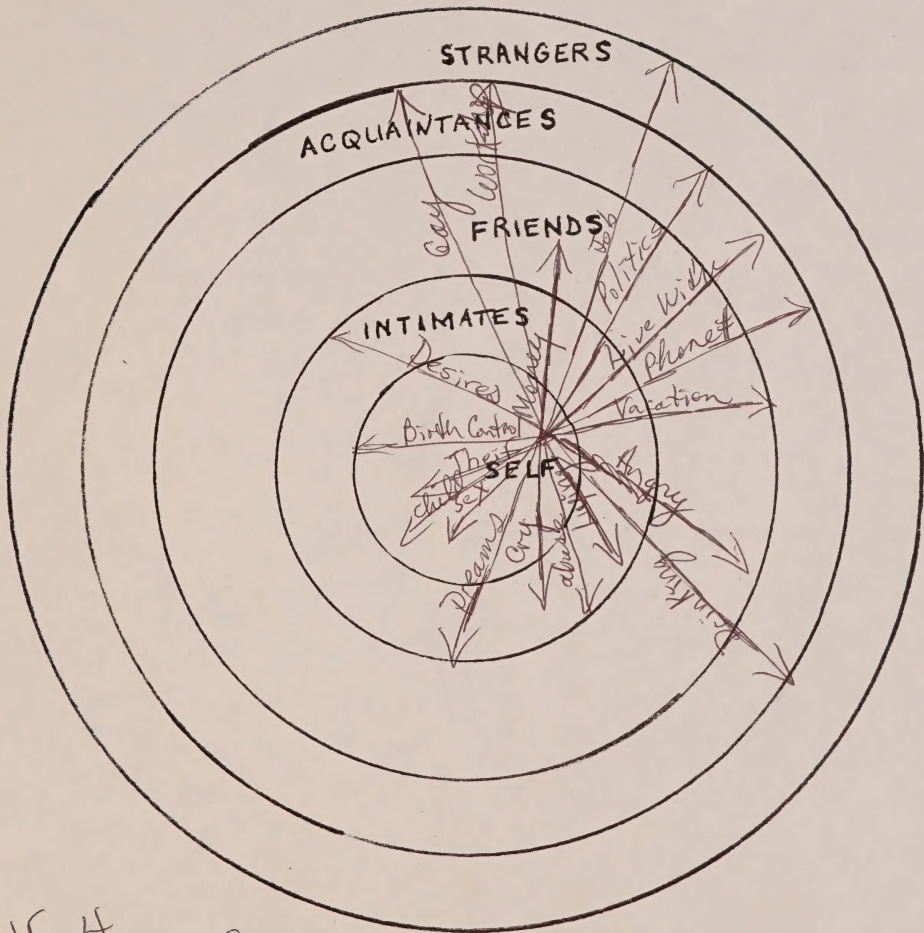
PLEASE RESPECT EACH OTHER'S
CONFIDENTIALITY. ANYTHING SHARED
IN THIS ROOM STAYS IN THIS ROOM.

MANAGEMENT OF CONFLICT: DYADIC SHARING

(THE DIRECTIONS FOR THIS PROJECT WILL BE PROVIDED BY THE PRESENTER.)

1. Your Name: If you had the choice of any name, what name would you prefer to have?
2. What single word best describes you?
3. Describe the single most important attribute of a leader.
4. What is your greatest strength?
5. What is your greatest weakness?
6. Describe the one quality that is most important to you in your relationships.
7. Conflict is
8. The time I felt best about dealing with conflict was when
9. When someone disagrees with me about something important or challenges me in front of others, I usually
10. The most important outcome of conflict is
11. I feel most vulnerable during a conflict when
12. My greatest strength in handling conflict is
13. I am most apt to confront people in situations such as
14. My greatest weakness in handling conflict is
15. When I think about confronting a potentially unpleasant person, I
16. By next year, I would like to be able to handle conflict better by improving my ability to

PRIVACY CIRCLE



Self 4
 Intimates 5 9
 Friends 3
 Acq 6 10
 Strangers 1

